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State/Territory: MINNESOTA

Citation 4.5 Medicaid Agency Fraud Detection and Investigation Program

42 CFR 455.12;
§1902(a)(64);
AT-78-90;
48 FR 3742;
52 FR 48817

The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR §455.13 through 42 CFR §455.21 and 42 CFR §455.23 for prevention and control of program fraud and abuse.

Minnesota's process for receiving and compiling data concerning alleged and actual instances of fraud, waste and abuse is as follows:

1. Reports from recipients -- Each Medicaid recipient receives an Explanation of Medical Benefits (EOMB), which contains the number of the Department's Recipient Help Desk. If a call is received by the Help Desk, all information is forwarded to the Department's Surveillance and Integrity Review (SIRS) Unit. The SIRS Unit confirms that the caller is a Medicaid recipient and, if further investigation is warranted:

- A. Recipient eligibility fraud: The SIRS Unit assigns the case to the Department's Program Assessment and Integrity (PAI) Unit. This unit supervises the work of county investigators, who work closely with county eligibility determination staff (financial workers).

The PAI Unit may also investigate eligibility fraud from reports received from county financial workers; from the fraud Hot Line (posted in each county public assistance office and listed in Medicaid brochures); or from law enforcement. The unit compiles data using a computer-based reporting system.

- B. Provider fraud: The SIRS Unit investigates and, if necessary, refers the case to the Attorney General.

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The SIRS Unit keeps a log of each call and all information received.

2. Reports from providers -- The Department's *Minnesota Health Care Programs Provider Manual* informs providers that suspected fraud or abuse should be reported to the SIRS Unit; additionally, providers are instructed to contact the Department's Primary Care Utilization Review Program with suspected or actual misutilization of services or drugs.

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